

Facility Name & ID Number Champaign County Nursing Home# 0001636 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>153</u>	Skilled (SNF)	<u>153</u>	<u>55,845</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>56</u>	Intermediate (ICF)	<u>56</u>	<u>20,440</u>	3
4		Intermediate/DD			4
5	<u>34</u>	Sheltered Care (SC)	<u>34</u>	<u>12,410</u>	5
6		ICF/DD 16 or Less			6
7	<u>243</u>	TOTALS	<u>243</u>	<u>88,695</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>888</u>	<u>891</u>	<u>5,537</u>	<u>7,316</u>	8
9	SNF/PED					9
10	ICF	<u>37,313</u>	<u>24,985</u>		<u>62,298</u>	10
11	ICF/DD					11
12	SC	<u>1,420</u>	<u>2,790</u>		<u>4,210</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,621</u>	<u>28,666</u>	<u>5,537</u>	<u>73,824</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.23%

D. How many bed-hold days during this year were paid by Public Aid?

27 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Adult Day Care; Child Day Care

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 1943

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date N/ANO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 153 and days of care provided 5,537Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 11/30/2003 Fiscal Year: 11/30/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	723,419	73,924	23,939	821,282		821,282	(3,502)	817,780			1
2	Food Purchase		456,164		456,164		456,164	(23,071)	433,093			2
3	Housekeeping	385,085	28,534		413,619		413,619	(2,595)	411,024			3
4	Laundry	129,251	26,221		155,472		155,472		155,472			4
5	Heat and Other Utilities			326,921	326,921		326,921	(28,348)	298,573			5
6	Maintenance	72,606	12,264	92,037	176,907		176,907	(8,633)	168,274			6
7	Other (specify):*											7
8	TOTAL General Services	1,310,361	597,107	442,897	2,350,365		2,350,365	(66,149)	2,284,216			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	3,633,899	225,591	150,694	4,010,184		4,010,184		4,010,184			10
10a	Therapy	1,550	989	284,099	286,638		286,638		286,638			10a
11	Activities	200,025	266	4,164	204,455		204,455	(1,200)	203,255			11
12	Social Services	129,547	27		129,574		129,574		129,574			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Day Care Expenses	320,203	2,091	4,922	327,216		327,216	(327,216)				15
16	TOTAL Health Care and Programs	4,285,224	228,964	448,079	4,962,267		4,962,267	(328,416)	4,633,851			16
	C. General Administration											
17	Administrative	91,268		46,561	137,829		137,829	(1,041)	136,788			17
18	Directors Fees											18
19	Professional Services			31,993	31,993		31,993	(813)	31,180			19
20	Dues, Fees, Subscriptions & Promotions			25,248	25,248		25,248	(1,871)	23,377			20
21	Clerical & General Office Expenses	336,926	15,174	63,415	415,515		415,515	(1,941)	413,574			21
22	Employee Benefits & Payroll Taxes			1,380,978	1,380,978		1,380,978	(59,175)	1,321,803			22
23	Inservice Training & Education			2,289	2,289		2,289	(200)	2,089			23
24	Travel and Seminar			9,018	9,018		9,018	(797)	8,221			24
25	Other Admin. Staff Transportation			1,696	1,696		1,696	(14)	1,682			25
26	Insurance-Prop.Liab.Malpractice			209,705	209,705		209,705	(7,758)	201,947			26
27	Other (specify):*											27
28	TOTAL General Administration	428,194	15,174	1,770,903	2,214,271		2,214,271	(73,610)	2,140,661			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,023,779	841,245	2,661,879	9,526,903		9,526,903	(468,175)	9,058,728			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			262,144	262,144		262,144	(32,669)	229,475			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,143	6,143		6,143		6,143			35
36	Other (specify):*											36
37	TOTAL Ownership			268,287	268,287		268,287	(32,669)	235,618			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,794		123,794		123,794		123,794			39
40	Barber and Beauty Shops	49,138	1,400		50,538		50,538		50,538			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,427	114,427		114,427		114,427			42
43	Other (specify):* Nonallowable Costs			59,174	59,174		59,174	(59,174)				43
44	TOTAL Special Cost Centers	49,138	125,194	173,601	347,933		347,933	(59,174)	288,759			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,072,917	966,439	3,103,767	10,143,123		10,143,123	(560,018)	9,583,105			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$ (327,216)	15		1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(30)	43		17
18 Fines and Penalties	(14,835)	43		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(24,551)	43		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(19,187)	43		24
25 Fund Raising, Advertising and Promotional	(571)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(173,628)	var.		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (560,018)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (560,018)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home
Facility #0001636
11/30/03

Page 5 - Line 29 - Other Non-Allowable Costs

<u>Description</u>	<u>Amount</u>	<u>Reference</u>
Kiwanis dues	(168)	20
Promotional advertising	(1,703)	20
Out of state seminars	(797)	24
Offset Candy fundraiser income	(1,200)	11
Inservice & Training	(200)	23
Daycare		
Dietary	(3,502)	1
Food	(17,153)	2
Housekeeping	(2,595)	3
Utilities	(28,348)	5
Maintenance	(8,633)	6
Administrative	(1,041)	17
Professional fees	(813)	19
Office expense	(1,941)	21
Employee benefits	(65,093)	22
Staff transportation	(14)	25
Insurance	(7,758)	26
Depreciation	(32,669)	30
	<u>(173,628)</u>	

Champaign County Nursing Home

ID# 0001636

Report Period Beginning: 12/01/2002

Ending: 11/30/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountants' Compilation Report

Summary A

11/30/2003

[illegible]

Facility Name & ID Number Champaign County Nursing Home# 0001636

Report Period Beginning:

12/01/2002

Ending:

11/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Champaign County	100	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Treasury Services	\$ 6,260	Champaign County	100.00%	\$ 6,260	\$ 1
2	V	17 Auditor's Office Services	40,301	Champaign County	100.00%	40,301	2
3	V	22 IMRF	214,101	Champaign County	100.00%	214,101	3
4	V	22 FICA	445,796	Champaign County	100.00%	445,796	4
5	V	22 Workers Compensation Ins.	292,312	Champaign County	100.00%	292,312	5
6	V	22 Unemployment Insurance	45,901	Champaign County	100.00%	45,901	6
7	V	22 Health Insurance	364,736	Champaign County	100.00%	364,736	7
8	V						8
9	V						9
10	V			Recorded on facility books and included on Schedule V, Column 3			10
11	V						11
12	V						12
13	V						13
14	Total		\$ 1,409,407			\$ 1,409,407	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	See attached list	Board of Directors	Administrative	0.00	None		<1%		None	N/A	2
3											3
4											4
5											5
6	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business										6
7	transactions with the nursing home during the reporting period.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home# 0001636 Report Period Beginning: 12/01/2002 Ending: 1/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Champaign County
 Street Address 1776 East Washington
 City / State / Zip Code Urbana, IL 61802
 Phone Number (217) 384-3776
 Fax Number (217) 337-0120

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Treasury Services	Direct Costs	All Co. Depts.	\$	\$	1	\$ 6,260	1
2	17	Auditor's Office Services	Direct Costs	All Co. Depts.			1	40,301	2
3	22	IMRF	Direct Costs	All Co. Depts.			1	214,101	3
4	22	FICA	Direct Costs	All Co. Depts.			1	445,796	4
5	22	Workers Compensation Ins.	Direct Costs	All Co. Depts.			1	292,312	5
6	22	Unemployment Insurance	Direct Costs	All Co. Depts.			1	45,901	6
7	22	Health Insurance	Direct Costs	All Co. Depts.			1	364,736	7
8									8
9									9
10									10
11		Recorded on facility books and included on Schedule V, Column 3							11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 1,409,407	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home# 0001636 Report Period Beginning: 12/01/2002 Ending: 1/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Champaign County Day Care
 Street Address 1701 East Main St.
 City / State / Zip Code Urbana, IL 61802
 Phone Number (217) 384-3784
 Fax Number (217) 337-0120

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	1	Dietary	Meals	230,989		\$ 99,049	\$	8,167	\$ 3,502	1	
2	2	Food	Meals	230,989		485,143		8,167	17,153	2	
3	3	Housekeeping	Square Feet	63,455		27,075		6,082	2,595	3	
4	5	Utilities	Square Feet	63,455		295,759		6,082	28,348	4	
5	6	Maintenance	Square Feet	63,455		90,067		6,082	8,633	5	
6	17	Administrative	Revenue	8,957,183		43,597		213,906	1,041	6	
7	19	Professional Fees	Revenue	8,957,183		34,025		213,906	813	7	
8	21	Office Expense	Revenue	8,957,183		81,260		213,906	1,941	8	
9	22	Employee Benefits	Salaries	6,072,917		1,180,363		334,902	65,093	9	
10	25	Staff Transportation	Revenue	8,957,183		590		213,906	14	10	
11	26	Insurance-Auto	Direct Allocation	1		4,064		1	4,064	11	
12	26	Insurance-Other	Revenue	8,957,183		154,681		213,906	3,694	12	
13	30	Depreciation-Auto	Direct Allocation	1		7,028		1	7,028	13	
14	30	Depreciation-Other	Square Feet	63,455		267,519		6,082	25,641	14	
15										15	
16										16	
17										17	
18		Day care cost eliminated on Schedule V - Column 7.									18
19										19	
20										20	
21										21	
22										22	
23										23	
24										24	
25	TOTALS					\$ 2,770,220	\$		\$ 169,560	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2				This Page Not Applicable								2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Champaign County Nursing Home**# **0001636** Report Period Beginning: **12/01/2002** Ending: **11/30/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2002 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1998</td><td>8</td></tr> <tr><td>1999</td><td>9</td></tr> <tr><td>2000</td><td>10</td></tr> <tr><td>2001</td><td>11</td></tr> <tr><td>2002</td><td>12</td></tr> </table>	1998	8	1999	9	2000	10	2001	11	2002	12	<table border="1"> <tr> <td></td> <td>FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1998	8																											
1999	9																											
2000	10																											
2001	11																											
2002	12																											
	FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										
County Facility: Does not pay real estate tax.																												

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Home COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0001636

CONTACT PERSON REGARDING THIS REPORT Amanda Knight, Comptroller

TELEPHONE 217-384-3784 FAX #: 217-337-0120

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. Facility does not pay real estate taxes.		\$ N/A	\$
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

See Accountants' Compilation Report

A. Square Feet: 101,931

B. General Construction Type:
 Exterior Brick
 Frame Reinforced Concrete
 Number of Stories 2

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident care	1,859,520	1865	\$ 2,100	1
2					2
3	TOTALS	1,859,520		\$ 2,100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

0001636

Report Period Beginning:

12/01/2002 Ending: 11/30/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	153	1975	1973	\$ 2,085,435	\$ 52,136	40	\$ 52,136		\$ 1,577,111
5	56	1910	1971	734,760		25			734,760
6	34		1971	207,240		25			207,240
7		1989	1989	34,891	872	40	872		12,652
8									
Improvement Type**									
9	Building improvements	1972		10,300		25			10,300
10	Building improvements	1973		146,645		25			146,645
11	Building improvements	1974		288,473		25			288,473
12	Building improvements	1974		18,482	462	40	462		13,568
13	Building improvements	1975		25,353		25			25,353
14	Building improvements	1976		6,342		15			6,342
15	Building improvements	1977		3,399		15			3,399
16	Building improvements	1977		8,548		25			8,548
17	Building improvements	1980		2,469		15			2,469
18	Building improvements	1981		36,818		15			36,818
19	Building improvements	1982		57,322		15			57,322
20	Building improvements	1983		31,084		10			31,084
21	Building improvements	1984		223,985	9,344	24	9,344		182,212
22	Building improvements	1985		57,958	2,953	20	2,953		53,173
23	Building improvements	1986		254,092	10,164	25	10,164		177,865
24	Building improvements	1987		81,739	4,153	20	4,153		68,533
25	Building improvements	1988		345,563	13,823	25	13,823		214,250
26	Building improvements	1989		64,947	2,598	25	2,598		37,670
27	Building improvements	1990		251,292	10,052	25	10,052		135,698
28	Building improvements	1991		163,384	6,535	25	6,535		81,691
29	Building improvements	1992		138,101	5,524	25	5,524		63,527
30	Building improvements	1993		62,716	2,509	25	2,509		26,341
31	Building improvements	1994		360,106	14,404	25	14,404		136,840
32	Building improvements	1995		28,420	1,138	25	1,138		9,670
33	Building improvements	1996		21,058	842	15	842		6,317
34	Parking lot	1977		25,035		15			25,035
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Tree care	1981	\$ 465	\$	15	\$	\$	\$ 465		37
38	Landscaping additions	1982	1,870		10			1,870		38
39	Landscaping additions	1983	5,250		5			5,250		39
40	Landscaping additions	1987	3,491		5			3,491		40
41	Landscaping additions	1988	1,971	66	15	66		1,971		41
42	Landscaping additions	1989	6,125	392	15	392		5,905		42
43	Landscaping additions	1990	3,596	240	15	240		3,237		43
44	Landscaping additions	1991	11,069	738	15	738		9,230		44
45	Landscaping additions	1992	2,969	198	15	198		2,277		45
46	Parking lot expansion	1996	67,139	4,602	15	4,602		34,825		46
47	Smoke detectors	1997	4,524		5			4,524		47
48	Redecorating-ADC	1997	1,459		5			1,459		48
49	Sprinkler backflow preventor	1997	6,230	623	10	623		4,050		49
50	Fire door - Activity office	1997	626	63	10	63		408		50
51	Wall-Dietary	1997	705	70	10	70		457		51
52	Mini blinds - Dining area	1997	1,045		5			1,045		52
53	Tuckpointing - Administration bldg	1997	11,400	456	25	456		2,964		53
54	Flooring improvements	1997	3,306		5			3,306		54
55	Asbestos removal	1998	45,350	1,814	25	1,814		9,967		55
56	Project planning - ARD expansion	1998	35,513	3,551	5	3,551		35,513		56
57	Air conditioning - Chiller replacement	1998	193,611	9,272	20	9,272		51,429		57
58	Hot water treatment system	1998	1,422	143	5	143		1,422		58
59	Pipe insulation	1998	3,201	160	20	160		880		59
60	Door sensor beam	1998	567	57	5	57		567		60
61	Vanity replacement (wing)	1998	16,236	812	20	812		4,465		61
62	Shower tile replacement (B wing)	1998	1,064	71	15	71		390		62
63	Heat exchanger replacement	1998	4,417	442	10	442		2,430		63
64	Pipe insulation	1998	97	5	20	5		27		64
65	Asbestos removal	1998	4,792	192	25	192		1,055		65
66	Cable for computer	1999	7,350	490	15	490		2,205		66
67	Chiller replacement electrical	1999	3,465	173	20	173		779		67
68	Door alarm on B wing	1999	1,808	181	10	181		814		68
69	Carpet - 3 offices	1999	814	163	5	163		733		69
70	TOTAL (lines 4 thru 69)		\$ 6,228,904	\$ 162,483		\$ 162,483	\$	\$ 4,580,316		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,228,904	\$ 162,483		\$ 162,483	\$	\$ 4,580,316	1
2	Door alarm hook-up	1999	50	5	10	5		23	2
3	Stainless steel wall coverings	1999	1,382	69	20	69		311	3
4	Flipper cabinet w/ hanging tracks	1999	297	20	15	20		90	4
5	Flipper cabinet w/ hanging tracks	1999	1,216	81	15	81		365	5
6	Door magnets (door alarms)	1999	144	14	10	14		64	6
7	Ceramic flooring	1999	3,192	160	20	160		719	7
8	Carpet in 2 offices	1999	918	184	5	184		827	8
9	Hollow metal door	1999	788	39	20	39		176	9
10	Annunciator	1999	400	40	10	40		180	10
11	Unit heater for bus ban	1999	569	38	15	38		171	11
12	Privacy panels & hardware	1999	518	104	5	104		467	12
13	A-wing nursing station	1999	4,333	289	15	289		1,300	13
14	Hook-up call system	1999	734	49	15	49		220	14
15	Computer cable	2000	810	54	15	54		203	15
16	Stainless folding for shower rooms	2000	578	58	15	58		217	16
17	Vinyl flooring	2000	960	192	10	192		592	17
18	Concrete fountain	2000	1,000	40	25	40		140	18
19	Remodel Annex corner	2001	443	87	5	87		196	19
20	Conversion of Activity room to Dining	2001	2,079	416	5	416		936	20
21	Major repair-Walk-in refrigerator	2001	526	105	5	105		219	21
22	Vinyl flooring	2001	898	180	5	180		367	22
23	Stairway treads	2001	1,495	299	5	299		610	23
24	Carpet - Canopy walkway	2001	980	196	5	196		408	24
25	Tree removal	2001	975	98	10	98		252	25
26	Fire alarm update	2001	1,273	127	10	127		360	26
27	Dishwasher fan	2001	4,285	429	10	429		1,144	27
28	ADC alarm	2001	566	57	10	57		152	28
29	Activity room phone system	2001	110	11	10	11		26	29
30	Wing door alarm	2001	886	89	10	89		222	30
31	Door alarm system	2001	857	86	10	86		208	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,262,166	\$ 166,099		\$ 166,099	\$	\$ 4,591,481	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 6,262,166	\$ 166,099		\$ 166,099		\$ 4,591,481		1
2	Hollow doors (3)	2002	635	32	20	32		61		2
3	Hollow door (1)	2002	514	26	20	26		45		3
4	Smoke detectors in ductwork	2002	23,325	2,333	10	2,333		4,147		4
5	Ductwork repair per Life Safety survey	2002	20,469	2,047	10	2,047		3,581		5
6	Smoke detectors in ductwork	2002	15,829	1,583	10	1,583		2,441		6
7	Air conditioner condensing unit	2002	971	65	15	65		87		7
8	Garage Door Repairs	2002	565	38	15	38		48		8
9	Removal of trees	2002	1,800	180	10	180		200		9
10	Sprinkler System Repair	2003	1,569	63	25	63		63		10
11	Compressor - Air Conditioner	2003	27,800	927	15	927		927		11
12	Heat Exchanger Repair	2003	5,559	31	15	31		31		12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20	Less: Allocated to Day Care			(32,669)		(32,669)				20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 6,361,202	\$ 140,755		\$ 140,755		\$ 4,603,112		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Champaign County Nursing Home# 0001636

Report Period Beginning:

12/01/2002

Ending:

11/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,524,097	\$ 79,605	\$ 79,605	\$	3-15	\$ 1,286,512	71
72	Current Year Purchases	14,781	1,933	1,933		3-10	1,933	72
73	Fully Depreciated Assets	391,350					391,350	73
74								74
75	TOTALS	\$ 1,930,228	\$ 81,538	\$ 81,538	\$		\$ 1,679,795	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident use	96 Ford Bus	1996	\$ 36,532	\$ 3,653	\$ 3,653	\$	10	\$ 27,400	76
77	Resident use	98 Dodge Van	1998	33,746	3,375	3,375		10	18,561	77
78	Resident use	Lift for Van	2001	537	107	107		5	250	78
79	Resident use	97 Ford	2002	1,898	47	47		10	94	79
80	TOTALS			\$ 72,713	\$ 7,182	\$ 7,182	\$		\$ 46,305	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,366,243	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 229,475	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,475	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,329,212	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Design & legal fees for	\$ 170,406	92
93	new facility		93
94			94
95		\$ 170,406	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 11/30/2003

A. Building and Fixed Equipment (See instructions.)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES ☐ NO

14. _____ /2006 \$ _____

9. Option to Buy: ☐ YES ☐ NO Terms:

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

(Attach a schedule detailing the breakdown of movable equipment)

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	Champaign County Nursing Home	Schedule 14A
Year Ended	11/30/2003	

Equipment Leasing Recap

Description of Equipment	Amount
Trash Compactor	2,948
Mattress	3,065
Compressor	130

Total per General Ledger	<u>6,143</u>
--------------------------	--------------

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(1, 2, 3)	220 hrs	\$ 1,550	5,912	\$ 85,385	\$ 414	6,132	\$ 87,349	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,964	42,831		2,964	42,831	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2, 3)	hrs		9,524	137,583	575	9,524	138,158	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				123,794		123,794	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 1,550	18,400	\$ 265,799	\$ 124,783	18,620	\$ 392,132	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

Provider #: 0001636

12/01/2002 to 11/30/2003

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Champaign County Nursing Home

0001636

Report Period Beginning: 12/01/2002

Ending:

11/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,477,525	\$ 1,477,525	1
2	Cash-Patient Deposits	16,862	16,862	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 71,774)	996,887	996,887	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	25,739	25,739	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36,838	36,838	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached	12,504	12,504	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,566,355	\$ 2,566,355	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,100	2,100	13
14	Buildings, at Historical Cost	6,228,446	6,228,446	14
15	Leasehold Improvements, at Historical Cost	132,756	132,756	15
16	Equipment, at Historical Cost	2,002,941	2,002,941	16
17	Accumulated Depreciation (book methods)	(6,329,212)	(6,329,212)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Const. In Progress)	170,406	170,406	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,207,437	\$ 2,207,437	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,773,792	\$ 4,773,792	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 195,730	\$ 195,730	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,922	16,922	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	345,382	345,382	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to other funds	215,901	215,901	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 773,935	\$ 773,935	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 773,935	\$ 773,935	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,999,857	\$ 3,999,857	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,773,792	\$ 4,773,792	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Champaign County Nursing Home

Facility #0001636

Page 17 - Attachments

11/30/03

Line 9 - Other

Due from other funds	5,900
Due from other government units	78
Due from accounts payable fund	<u>6,526</u>
Total - Line 9	<u><u>12,504</u></u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,941,130	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,941,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	58,728	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 58,727	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,999,857	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Champaign County Nursing Home

0001636

Report Period Beginning: 12/01/2002

Ending: 11/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,957,183	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,957,183	3
B. Ancillary Revenue			
4	Day Care	213,906	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 213,906	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	123,582	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	49,526	13
14	Non-Patient Meals	3,014	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	96,368	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 272,490	23
D. Non-Operating Revenue			
24	Contributions	16,093	24
25	Interest and Other Investment Income***	11,879	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,972	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached	689,893	28
28a	Inter-fund transfer from General Account	40,407	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 730,300	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,201,851	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	2,350,365	31
32	Health Care	4,962,267	32
33	General Administration	2,214,271	33
B. Capital Expense			
34	Ownership	268,287	34
C. Ancillary Expense			
35	Special Cost Centers	233,506	35
36	Provider Participation Fee	114,427	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,143,123	40
41	Income before Income Taxes (line 30 minus line 40)**	58,728	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 58,728	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility files as part of County return

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Champaign County Nursing Home
Facility #0001636
11/30/03

Page 19 - Line 28 - Other Operating Revenue

<u>Description</u>	<u>Amount</u>
Taxes: Current -Nursing Home	677,910
Mobile Home Tax	1,428
Payment in Lieu of Taxes	296
Local Gvmt: Cunningham Township	129
Resident transportation charge	3,420
Late charges, NSF check charges	4,764
Workers Comp reimbursements	223
Other miscellaneous revenue:	
Candy bar fundraiser	1,200
Jury pay, employee reimbursements , etc.	523
	<hr/>
	689,893
	<hr/> <hr/>

Facility Name & ID Number **Champaign County Nursing Home**# **0001636**Report Period Beginning: **12/01/2002**Ending: **11/30/2003**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,411	2,430	\$ 73,945	\$ 30.43	1
2	Assistant Director of Nursing	2,158	2,175	55,309	25.43	2
3	Registered Nurses	21,116	21,286	467,142	21.95	3
4	Licensed Practical Nurses	31,250	31,502	525,089	16.67	4
5	Nurse Aides & Orderlies	164,811	165,333	1,985,519	12.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	120	124	1,550	12.50	7
8	Rehab/Therapy Aides	5,848	5,895	68,143	11.56	8
9	Activity Director	2,182	2,200	43,763	19.89	9
10	Activity Assistants	14,773	14,892	156,262	10.49	10
11	Social Service Workers	8,322	8,389	129,547	15.44	11
12	Dietician					12
13	Food Service Supervisor	2,280	2,298	53,857	23.44	13
14	Head Cook	1,421	1,432	27,239	19.02	14
15	Cook Helpers/Assistants	17,187	17,326	199,986	11.54	15
16	Dishwashers	52,893	53,320	442,337	8.30	16
17	Maintenance Workers	6,146	6,196	72,606	11.72	17
18	Housekeepers	38,914	39,228	385,085	9.82	18
19	Laundry	13,818	13,929	129,251	9.28	19
20	Administrator	2,197	2,215	91,268	41.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,367	23,556	336,926	14.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,084	2,101	20,545	9.78	31
32	Other Health C: (See attached)	21,209	21,380	438,207	20.50	32
33	Other(specify) (See attached)	30,083	30,326	369,341	12.18	33
34	TOTAL (lines 1 - 33)	464,590	467,533	\$ 6,072,917 *	\$ 12.99	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	456	\$ 23,939	1(3)	35
36	Medical Director	Monthly	4,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	306	3,600	10(3)	39
40	Physical Therapy Consultant	158	9,480	10A(3)	40
41	Occupational Therapy Consultant	98	5,880	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	49	2,940	10A(3)	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,067	\$ 50,039		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	553	\$ 24,652	10(3)	50
51	Licensed Practical Nurses	1,458	50,018	10(3)	51
52	Nurse Aides	204	4,484	10(3)	52
53	TOTAL (lines 50 - 52)	2,215	\$ 79,154		53

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home
 Facility #0001636
 11/30/03

Page 20 - Lines 32 & 33 - Other Wages

	<u>Actually Worked</u>	<u>Paid & Accrued</u>	<u>Total Salary & Wages</u>	<u>Hourly Wage</u>
<u>Line 32 - Other Health Care</u>				
Restorative Care Coordinator	2,317	2,336	49,693	21.27
Dental Hygienist	1,584	1,597	35,619	22.30
Care Plan Coordinator	1,258	1,268	24,859	19.60
QA/Staff Development Coord.	2,113	2,130	50,504	23.71
Nursing Services Coordinator	9,848	9,927	237,470	23.92
Unit Secretary	4,089	4,122	40,062	9.72
	<u>21,209</u>	<u>21,380</u>	<u>438,207</u>	<u>20.50</u>

Line 33 - Other Wages

Barber & Beauty	4,730	4,768	49,138	10.31
Adult Day Care	11,133	11,223	125,230	11.16
Child Day Care	14,220	14,335	194,973	13.60
	<u>30,083</u>	<u>30,326</u>	<u>369,341</u>	<u>12.18</u>

Facility Name & ID Number Champaign County Nursing Home

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Champaign County Nursing Home

Provider #: 0001636

12/01/2002 to 11/30/2003

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Total Page 21		20,738.00
Jeremy Maupin	Internet Service	263.00
Ivans	Software Support	2,830.00
Senior Living Systems	Software Support	6,468.00
Menu Systems	Software Support	258.00
Arends & Sons	Software Support	35.00
Ban-Koe Systems	Software Support	313.00
Capital One, FSB	Internet Service	72.00
Champaign Co. Treasurer	Internet Connection	1,016.00
Total (agree to Schedule V, line 19, column 3)		31,993.00
Allocated to Day Care and eliminated		(813.00)
Total (agree to Schedule V, line 19, column 8)		<u>31,180.00</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home

STATE OF ILLINOIS

0001636

Report Period Beginning: 12/01/2002

Page 23

Ending: 11/30/2003

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See attached 13,883
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81,998 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 114,427
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes-See page 8A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 5,918 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Bray, Drake, Guthrie & Richardson The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Champaign County Nursing Home

Provider #: 0001636

12/01/2002 to 11/30/2003

Schedule 23A

XX. GENERAL INFORMATION

2. Nursing Home Association Dues

<u>Vendor/Payee</u>	<u>Amount</u>
Illinois Health Care Assoc.	11,823
County Nursing Home Assoc. of IL	2,060
Total	<u>13,883</u>

RECONCILIATION REPORT

Champaign County Nurs

11:26 AM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-560,018	equal to	-560,018	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	229,475	equal to	229,475	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,143	equal to	6,143	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages	1,550	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	286,638	equal to	286,638	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	124,783	equal to	124,783	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,350,365	equal to	2,350,365	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,962,267	equal to	4,962,267	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,214,271	equal to	2,214,271	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	268,287	equal to	268,287	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	233,506	equal to	233,506	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	114,427	equal to	114,427	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,127,549	equal to	3,633,899	-506,350	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	1,550	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	200,025	equal to	200,025	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	129,547	equal to	129,547	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	723,419	equal to	723,419	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	72,606	equal to	72,606	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	385,085	equal to	385,085	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	129,251	equal to	129,251	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	91,268	equal to	91,268	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	336,926	equal to	336,926	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	6,072,917	equal to	6,072,917	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	23,939	< or = to	23,939	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,200	< or = to	4,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	82,754	< or = to	150,694	-67,940	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	4,164	-4,164	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	91,268	equal to	91,268	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	46,561	equal to	46,561	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	31,993	equal to	31,993	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,321,803	equal to	1,321,803	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	23,377	equal to	23,377	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	8,221	equal to	8,221	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	114,427	equal to	114,427	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	5,918	< or = to	-59,175	65,093	FAILED	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	5,918	equal to	5,918	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,537	equal to	5,537	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	0	equal to	0	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	2,100	equal to	2,100	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,361,202	equal to	6,361,202	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	2,002,941	equal to	2,002,941	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	6,329,212	equal to	6,329,212	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,999,857	equal to	3,999,857	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	58,728	equal to	58,728	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,773,792	equal to	4,773,792	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	723,419	73,924	23,939	821,282	0	821,282	-3,502	817,780
2. Food Purchase	0	456,164	0	456,164	0	456,164	-23,071	433,093
3. Housekeeping	385,085	28,534	0	413,619	0	413,619	-2,595	411,024
4. Laundry	129,251	26,221	0	155,472	0	155,472	0	155,472
5. Heat and Other Utilities	0	0	326,921	326,921	0	326,921	-28,348	298,573
6. Maintenance	72,606	12,264	92,037	176,907	0	176,907	-8,633	168,274
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,310,361	597,107	442,897	2,350,365	0	2,350,365	-66,149	2,284,216
9. Medical Director	0	0	4,200	4,200	0	4,200	0	4,200
10. Nursing & Medical Records	3,633,899	225,591	150,694	4,010,184	0	4,010,184	0	4,010,184
10a. Therapy	1,550	989	284,099	286,638	0	286,638	0	286,638
11. Activities	200,025	266	4,164	204,455	0	204,455	-1,200	203,255
12. Social Services	129,547	27	0	129,574	0	129,574	0	129,574
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	320,203	2,091	4,922	327,216	0	327,216	-327,216	0
16. Total Health Care & Programs	4,285,224	228,964	448,079	4,962,267	0	4,962,267	-328,416	4,633,851
17. Administrative	91,268	0	46,561	137,829	0	137,829	-1,041	136,788
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	31,993	31,993	0	31,993	-813	31,180
20. Fees, Subscriptions & Promotion	0	0	25,248	25,248	0	25,248	-1,871	23,377
21. Clerical & General Office	336,926	15,174	63,415	415,515	0	415,515	-1,941	413,574
22. Employee Benefits & Payroll	0	0	1,380,978	1,380,978	0	1,380,978	-59,175	1,321,803
23. Inservice Training & Education	0	0	2,289	2,289	0	2,289	-200	2,089
24. Travel and Seminar	0	0	9,018	9,018	0	9,018	-797	8,221
25. Other Admin. Staff Trans	0	0	1,696	1,696	0	1,696	-14	1,682
26. Insurance-Prop.Liab.Malpractice	0	0	209,705	209,705	0	209,705	-7,758	201,947
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	428,194	15,174	1,770,903	2,214,271	0	2,214,271	-73,610	2,140,661
29. Total General Administrative	6,023,779	841,245	2,661,879	9,526,903	0	9,526,903	-468,175	9,058,728
30. Depreciation	0	0	262,144	262,144	0	262,144	-32,669	229,475
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	6,143	6,143	0	6,143	0	6,143
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	268,287	268,287	0	268,287	-32,669	235,618
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	123,794	0	123,794	0	123,794	0	123,794
40. Barber and Beauty Shop	49,138	1,400	0	50,538	0	50,538	0	50,538
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	114,427	114,427	0	114,427	0	114,427
43. Other (specify):*	0	0	59,174	59,174	0	59,174	-59,174	0
44. Total Special Cost Ce	49,138	125,194	173,601	347,933	0	347,933	-59,174	288,759
45. Grand Total	6,072,917	966,439	3,103,767	10,143,123	0	10,143,123	-560,018	9,583,105

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,477,525	1,477,525
2. Cash - Patient Deposits	16,862	16,862
3. Accounts & Notes Recievable	996,887	996,887
4. Supply Inventory	0	0
5. Short-Term Investments	25,739	25,739
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	36,838	36,838
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	12,504	12,504
10. Total current assets	2,566,355	2,566,355
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	6,228,446	6,228,446
15. Leasehold Improvements, Historical Cost	132,756	132,756
16. Equipment, at Historical Cost	2,005,041	2,005,041
17. Accumulated Depreciation (book methods)	-6,329,212	-6,329,212
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	170,406	170,406
23. other (specify):	0	0
24. Total Long-Term Assets	2,207,437	2,207,437
25. Total Assets	4,773,792	4,773,792
CURRENT LIABILITIES		
26. Accounts Payable	195,730	195,730
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	16,922	16,922
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	345,382	345,382
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	215,901	215,901
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	773,935	773,935
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	773,935	773,935
47.Total Equity	3,999,857	3,999,857
48.Total Liabilities and Equity	4,773,792	4,773,792

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,957,183
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	8,957,183
4. Day Care	213,906
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	213,906
9. Payments for Education	0
10. Other Governmental Grants	123,582
11. Nurses Aide Training Reimbursements -	
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	49,526
14. Non-Patient Meals	3,014
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	96,368
22. Laundry	0
Subtotal - Other Operating Revenue	272,490
24. Contributions	16,093
25. Interest and Other Investments Income	11,879
Subtotal - Non-Operating Revenue	27,972
27. Other Revenue (specify):	689,893
28. Other Revenue (specify):	40,407
Subtotal - Other Revenue	730,300
30. Total Revenue	10,201,851
31. General Services	2,350,365
32. Health Care	4,962,267
33. General Administration	2,214,271
34. Ownership	268,287
35. Special Cost Centers	233,506
35. Provider Participation Fee	114,427
37. Other	0
40. Total Expenses	10,143,123
41. Income Before Income Taxes	58,728
42. Income Taxes	0
43. Net Income or Loss for the Year	58,728

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23 Provider Participation fee is linked from page 4